



Authorization to Release Protected Health Information

Place label or

1. PRINT Name _____ DOB ____/____/____

I hereby authorize the release / disclosure of the following specified information:

- ONLY the following: all Pap results including high-risk HPV and Colposcopy / LEEP records (Provider _____)
- Most recent annual exam / postpartum exam including chart notes, lab work, and Pap results (Provider _____)
- All health information generated by facility (do not send health information from other sources) (Provider _____)
- All health information kept at facility (do include health information from other sources) (Provider _____)
- Other, specify _____ (Provider _____)

2. Unless I have initialed below, I authorize the release of information regarding the following conditions:

_____ Drug abuse _____ Psychiatric _____ Alcohol abuse _____ HIV/AIDS

3. Purpose of release:

- Continuing medical care Personal use Insurance Legal Other _____

4. Check one: TO / FROM: **Boulder Valley Women's Health Center**
2855 Valmont Road
Boulder, CO 80301
Phone 303-442-5160 Fax 303-440-8769

5. Check one: TO / FROM: Facility/Provider/Individual _____
Address _____
City/State/Zip _____
Phone _____ Fax _____

6. By checking this box, I authorize sending this release and my health information via fax.

7. Check each box to indicate understanding.

- A copy of this authorization shall be utilized with the same effectiveness as the original.
- I understand that I may revoke this authorization at any time as stated in Notice of Health Info Practices.
- I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on the authorization.
- I understand that this authorization will expire one year from the date of this document, or: _____ (Date of Expiration).
- I understand that charges may be incurred for copying costs. The rate set by the State of Colorado is \$14.00 for the first 10 or fewer pages, 50 cents per page for pages 11-40, and then 33 cents per page after 40 pages.
- I understand that Women's Health may not condition treatment or payment on whether I sign this form.
- I understand that information that I have authorized be disclosed may be re-disclosed by the recipient and no longer will be protected by this authorization.

8. _____ / ____/____
Patient Signature Today's Date

Sent by _____ Date sent ____/____/____ RT PHI